AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with state and federal laws concerning the privacy of such information. Failure to provide *all* information requested may invalidate this Authorization.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Member/Individual Name: Richard Pence

Member/Individual ID/SSN: [redacted] Member/Individual DOB: [redacted]49

Persons/Organizations authorized to *use or disclose* the information: ValueOptions Employee Assistance Program (EAP)

Persons/Organizations authorized to *receive* the information: Tenneco

Purpose of requested use or disclosure: Compliance and / or non-compliance with formal or mandatory referral by employer

This Authorization applies to only the following records or types of health information (including any dates):

- ☑ Contact(s) with the EAP;
- ☑ Participation or non-participation in recommended plan of action;
- ☑ Continuation or discontinuation in recommended plan of action; and/or
- ☐ _____

This Authorization expires upon completion of all follow-up associated with such referral or one year from the date granted, whichever is later.

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization. Treatment, payment, enrollment or eligibility for benefits will NOT be conditioned on my providing or refusing to provide this Authorization.

I may take back ("revoke") this Authorization at any time. I must do this in writing, signed by me or on my behalf, and delivered to the following address: Value Options PO BOX 12458 RTP NC 27709

My revocation will be effective upon receipt, but will not affect actions already taken on the basis of this Authorization.

I have a right to receive a copy of this Authorization.

Except as set forth below with respect to drug and/or alcohol abuse records, information disclosed as a result of this Authorization could be redisclosed by the recipient and might no longer be protected by federal confidentiality laws.

EXHIBIT 2

I may inspect or obtain a copy of the health information to be used or disclosed as permitted under federal or state law.

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____

(Member/Individual/representative/spouse/financially responsible party)

If signed by someone other than the Member/Individual, state your legal relationship to the Member/Individual: _____

ACKNOWLEDGMENT OF RELEASE OF DRUG OR ALCOHOL ABUSE RECORDS -

I acknowledge that information to be used or disclosed as a result of this Authorization may include records that are protected by federal and/or state laws applicable to substance abuse. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information.

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____

(Member/Individual or, if Member/Individual has been adjudicated as incompetent for reasons other than insufficient age, Member's/Individual's personal representative)

Parent or guardian of minor Member/Individual if required by state law: _____